2011 Montana VFC Program Provider Agreement

Provider: _____

CONTACT NAME_____ PHONE_____

Your practice/clinic is a Health Department ☐ Private Practice ☐
Federally Qualified Health Center (FQHC) ☐ Rural Health Clinic (RHC) ☐

To participate in the Vaccines for Children (VFC) program and receive federally procured vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department, or other health delivery facility of which I am the physician-in-chief or equivalent:

1. I will screen patients and administer VFC program-purchased vaccine only to a child (≤18 years of age) who qualifies under one or more of the following categories: a) Is an American Indian or Alaskan Native; b) Is on Medicaid (or qualified through a State Medicaid waiver); c: Has no health insurance; or d) in the case of FQHCs or RHCs, has health insurance that does not pay for the vaccine.

2. I will administer VFC vaccines only to children in eligible age cohorts for each vaccine, as set by the Advisory Committee on Immunization Practices (ACIP) in VFC resolutions.

3. I will maintain parent/guardian responses on the Patient Eligibility Screening Record form for a period of 3 years. Release of such records will be bound by the privacy protection of the federal Medicaid law. Immunization records must be kept for at least 10 years.

4. If requested, I will make such records available to the Montana Department of Public Health and Human Services or the Department of Health and Human Services (DHHS).

5. I will comply with the appropriate immunization schedule, dosage, and contraindications that are established by the ACIP, unless a) in my medical judgement, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or b) the particular requirement contradicts the law in my State pertaining to religious or medical exemptions. Note: The ACIP Schedule is compatible with the AAP recommendations.

6. I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act, which includes reporting clinically significant adverse events to the Vaccine Adverse Reporting System.

7. I will not impose a charge for the cost of the vaccine.

8. I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by CMS regional fee cap of $14.13 per dose. For Medicaid VFC-eligible children, I agree to accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.

9. I will not deny administration of a federally procured vaccine to a child because the child's parent/guardian/individual of record is unable to pay the administration fee.

10. I will comply with the State's requirements for vaccine ordering, storage, monitoring, usage reporting, and the other requirements outlined for participation in the VFC Program in a manner intended to avoid fraud and abuse. I agree my practice is responsible for the federally purchased VFC vaccine.

11. The State may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons. If the agreement is terminated for any reason, I agree to properly return any unused VFC vaccine.

_____ _____
Provider of Record – Sign and Print name Date
(Must be a provider with prescription-writing privileges).

Please print or type the names and medical license numbers of the other health providers who may administer vaccine (attach copies of this sheet if additional space is needed). It is not necessary to include the names of all staff who may administer vaccine, but rather, only those who possess a medical license or are authorized to write prescriptions.

Last Name, First, MI	License Number	Title(MD,DO,NP,PA) (Provider must have prescriptive authority)

Please copy and add another page if you have more providers.